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Supreme Court, U.S.
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No. 96-291

IN THE
Supreme Court of the United States
OCTOBER TERM, 1995

BRIAN WING, as Acting Commissioner of the Department of Social Services of the State of New York,

Petitioner,

v.

JAMES SQUARE NURSING HOME, INC.,

Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Second Circuit

BRIEF IN OPPOSITION

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QUESTION PRESENTED

Respondent submits that the question presented for review is as follows:

When New York health care providers participating in Medicare serve patients that are eligible under both Medicare and Medicaid, the State of New York deems the amounts paid under the federal-State Medicaid program as the providers' only allowable compensation for the service rendered and requires that larger amounts paid by Medicare as the reasonable cost of rendering the services be paid over to the State. The question is whether that requirement is contrary to the federal Medicare and Medicaid Acts.

STATEMENT UNDER RULE 29.6

Respondent James Square Nursing Home, Inc. has no parent companies and no nonwholly-owned subsidiaries. Respondent James Square Nursing Home, Inc. has no parent companies and no nonwholly-owned subsidiaries.

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BRIEF IN OPPOSITION

Respondent James Square Nursing Home, Inc. ("James Square") opposes the petition for a writ of certiorari filed with the Court by Brian Wing, as Acting Commissioner of the Department of Social Services of the State of New York (the "Commissioner").

STATEMENT OF THE CASE

A. James Square's Action in the Court Below.

James Square operates a 455-bed residential skilled nursing facility in the State of New York. Its patients include persons entitled to health care services under the Health Insurance for the Aged and Disabled program established pursuant to Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 *et seq.* ("Medicare"), a federally-administered program for the aged and disabled, one component of which -- Medicare Part B -- is a voluntary program covering such health care services as physician care, physical therapy, drugs and laboratory services. James Square's patients also include persons eligible under the medical assistance program established pursuant to Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq.* ("Medicaid"), a State-administered program of medical assistance for financially needy persons. The Commissioner is the State official responsible for administering the Medicaid program in New York.

Payments for services covered by Medicare Part B (sometimes called "ancillary services") are financed by premiums paid by enrollees and contributions made by the federal government. After they have been rendered, the Secretary of Health and Human Services determines the

"reasonable costs or charges" for Medicare Part B services, and providers are entitled to 100 per cent of the amount determined.[1/] In general, 80 percent of the reasonable cost is payable by the federal government and 20 percent, called the "copayment," is payable by enrollees to whom the services have been rendered. The Medicare Act expressly permits a State, however, to enroll its "dual eligibles" -- persons eligible for both Medicaid and Medicare -- in Medicare Part B by entering a "buy-in" agreement with the federal government under which the State pays the annual premiums and any copayments and annual deductibles. 42 U.S.C. § 1395v. New York has entered into such a "buy-in" agreement.

Medicaid, on the other hand, is financed with both federal and State funds, with the federal share in New York being about fifty percent. Amounts paid under Medicaid are determined before the services are rendered and are based upon projections from actual costs incurred during a base period prior to the time the services are rendered. Because Medicare payment amounts are determined after the services are rendered and based upon actual costs incurred, Medicare payment amounts are directly correlated to costs incurred. By contrast, Medicaid payment amounts invariably are lower than the provider's actual costs attributable to the covered services.

Under both Medicare and Medicaid, James Square provides covered services to its patients and receives payments directly from the respective program administrator. Because James Square's patients include a number of "dual eligibles"

1/ Initial payments are made under Medicare Part B based upon the provider's charges for the covered service. The provider thereafter must file a cost report, and the final determination of the amount paid depends upon the actual costs incurred in rendering the services during the period covered by the report.

and Medicare coverage overlaps in some cases with Medicaid coverage, James Square sometimes would be entitled to collect payments for the same service under both programs. Under the guise of seeking to prevent such double payments, the Commissioner has adopted an "audit policy" to recover all Medicare payments received by health care providers for services that have been paid for under the Medicaid program -- even when, as almost always is the case, the Medicare payment exceeds the Medicaid payment for the same service. Under this policy, the Commissioner, in his audits of health care providers, seeks to require that they pay over to the State amounts that are greater than the amounts the providers are entitled to receive for rendering the same services to the same persons under the New York Medicaid program.

James Square brought an action in the district court below to enjoin the Commissioner from implementing the audit policy. Requiring James Square and other providers to pay over to the State amounts they have received under Medicare, James Square contends, is not necessary to prevent double compensation -- the sole reason the State gives for the policy. A simple recoupment of amounts paid under Medicaid in excess of amounts paid under the "buy-in" agreement -- thus leaving health care providers with only their Medicare payments and copayments -- would accomplish that purpose. Instead, the challenged New York audit policy allows the State to deprive providers of Medicare funds paid to them as reimbursement for costs they have incurred in rendering services covered by Medicare. The policy thus forces providers to accept below-cost payments for these services and gives the State a windfall every time it recovers an amount that is greater than the Medicaid payment for the same service. James Square challenged the policy as a violation of the

Medicare and Medicaid Acts and as an unconstitutional deprivation of its property.

B. Decisions of the Courts Below.

The district court below sustained James Square's claim under the Medicare and Medicaid Acts, holding that James Square's position is a corollary to the principle articulated in *New York City Health and Hosp. Corp. v. Perales*, 954 F.2d 854 (2d Cir.), *cert. denied*, 506 U.S. 972 (1992), that dual eligible patients "must be considered as primarily Medicare patients." *James Square Nursing Home, Inc. v. Wing*, 897 F. Supp. 682, 686 (N.D.N.Y. 1995) ("District Court Decision") (Petition at 16a). That principle reflects the statutory provision that "under the Medicare Act, 'providers who furnish medical care to Medicare-eligible patients have the right to collect 100% of their reasonable costs and charges.'" *Id.*, *quoting New York City Health*, 954 F.2d at 858. As the Second Circuit concluded in *New York City Health*, "a Medicare provider need not be satisfied with inadequate payment, *i.e.*, less than reasonable costs or charges, even when that provider is treating a Medicare patient who happens also to be poor." 954 F.2d at 860. The district court thus held that, if New York were to recover amounts in excess of the payments it has made under Medicaid in the circumstances of this case, the State would be "withholding from [James Square] federal funds intended for the provider of services." District Court Decision, 897 F. Supp. at 686-87 (Petition 17a).

The district court decreed that the New York Commissioner's "audit [policy] allowing an offset for the amount paid by Medicare for ancillary services violates the Medicare Act, 42 U.S.C. §§ 1395 *et seq.* and the Medicaid Act, 42 U.S.C. §§ 1396 *et seq.*," but did not rule on the

constitutional questions raised by James Square. District Court Decision, 897 F. Supp. at 687 (Petition 20a). On appeal, the Second Circuit affirmed the district court's judgment "substantially for the reasons set forth in its decision and order." *James Square Nursing Home, Inc. v. Wing*, 84 F.3d 591, 592 (2d Cir. 1996) ("Court of Appeals Decision") (Petition 7a).

REASONS FOR DENYING THE PETITION

The petition in this case states no substantial reason for the Court to review the judgment below. That judgment rightly condemns a policy under which the New York Medicaid program is unjustly enriched at the expense of health care providers rendering services to the poor for which they are entitled to full-cost reimbursement under the Medicare program. The principle that dual eligible patients are primarily Medicare patients has been recognized as inconsistent with such a policy not only by the court below, but also by three other circuits. *See Rehabilitation Ass'n of Virginia, Inc. v. Kozlowski*, 42 F.3d 1444 (4th Cir.), *cert. denied sub. nom. Metcalf v. Rehabilitation Ass'n of Virginia*, ___ U.S. ___, 116 S. Ct. 60 (1995); *Haynes Ambulance Serv., Inc. v. Alabama*, 36 F.3d 1074 (11th Cir. 1994); *Pennsylvania Medical Society v. Snider*, 29 F.3d 886 (3d Cir. 1994). In fact, the federal courts consistently have reached that result. *See Beverly Community Hosp. Ass'n v. Belshe*, No 95-4053 JSL, 64 USLW 2447 (C.D. Cal. Dec. 18, 1995), *appeal docketed* No 96-44208 (9th Cir. Feb. 1, 1996); *Paramount Health Systems, Inc. v. Wright*, No. 95-C-1620 (N.D. Ill. July 29, 1996). The federal decisions thus have established that Medicaid requirements cannot be imposed to deprive providers of reimbursement for their full Medicare-determined costs in serving dual eligible patients.

The Commissioner points out that two New York intermediate appellate courts have upheld its Medicare payment recovery policy. *Matter of Harr-Wood Nursing Home v. Perales*, 113 A.D.2d 535 (3d Dep't 1986); *Matter of Aurora Park Health Care Center v. Bane*, 209 A.D.2d 974 (4th Dep't 1994) (*dicta*). He cites no other State court decision. And, even in New York, the State's court of last resort has not ruled on the question. There consequently is no conflict between State and federal courts that presently need be resolved by this Court.

The primacy of Medicare over Medicaid when patients qualify for health care services under both programs emerges directly from the plain words of the Medicare Act and from the Congressional aversion to "a wealth-based, two-tiered system of health care for the elderly and certain disabled." *New York City Health.*, 954 F.2d at 859. "Congress has stated that Medicare providers shall be reimbursed for the reasonable costs, both direct and indirect, they incur in rendering health care services to Medicare beneficiaries." *Mercy Community Hosp. v. Heckler*, 781 F.2d 1552, 1556 (11th Cir. 1986), *citing* 42 U.S.C. §§ 1395f(b) and 1395x(v)(1)(A); *see also Northwest Hospital, Inc. v. Hospital Service Corp.*, 687 F.2d 985, 989 (7th Cir.1982) ("statutory touchstone is the reimbursement of actual costs, both direct and indirect, found to be not unnecessary to the efficient delivery of needed health services").

The Commissioner has advanced no justification for departure from these bedrock principles. As the district court below demonstrated, "limiting the state's offset to the amount it actually paid for services does not prevent Medicaid from being a payor of last resort." District Court Decision, 897 F. Supp. at 687 (Petition 19a). And the Commissioner's assertion

that he is unable to ascertain the portion of Medicaid payments that is allocable to services covered by Medicare was not accepted by the district court. As the court held, difficulty in developing a formula to reflect the percentage of Medicaid payments attributable to services covered by Medicare "does not absolve the state of its responsibility to do so" if it wishes to claim an offset for that percentage. *Id.*

Finally, the fact that New York extracts a commitment from health care providers to accept Medicaid payments as full compensation for the covered services does not support the State's practice of confiscating payments that providers receive from Medicare. The federal courts rightly have held that Medicare's primacy in cases of dual eligible patients overcomes any Medicaid policy designed to limit amounts paid for covered health care services. And Congress has specifically provided in 42 U.S.C § 1396a(n) that the State copayments under the Medicare program may result in the total Medicare compensation exceeding the amount otherwise payable under the Medicaid program. What is more, even were health care providers limited to the amounts paid by Medicaid in such cases, it does not follow that a State may enrich itself by requiring providers to pay their Medicare receipts over to the State.

In sum, New York's policy of making health care providers serve dual eligible patients for below-cost compensation and enriching its Medicaid program with Medicare funds intended for those patients has no legal basis. It violates the principle that federal courts have consistently followed -- that dual eligible patients must be deemed primarily Medicare patients. The fact that the decisions below deprive New York of the windfall it otherwise would receive by employing its audit policy -- which the Commissioner

estimates as totaling $42-92 million annually, including the 50% federal share (Petition 7-8) -- is no reason for this Court to review those decisions.

CONCLUSION

For the reasons stated, the petition for a writ of certiorari should be denied.

Respectfully submitted,

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